Learning Collaborative

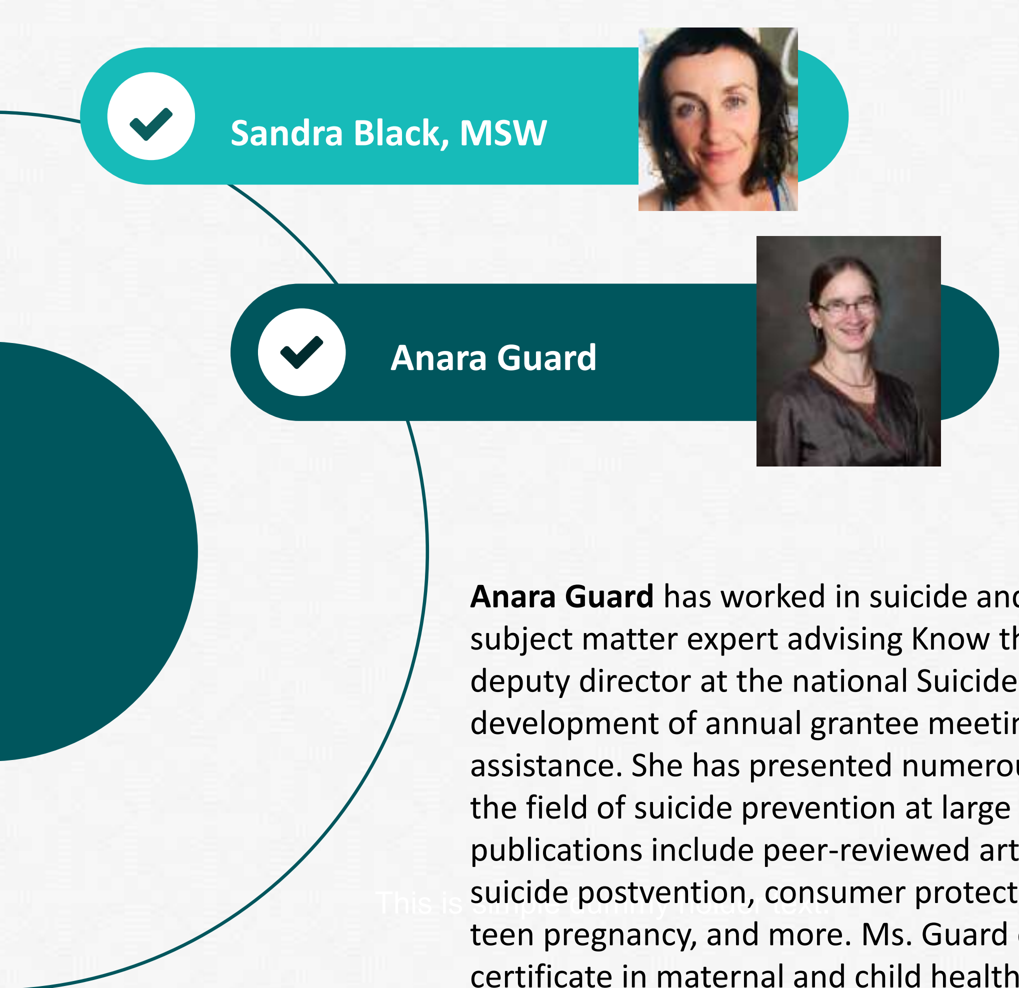
Strategic Planning for Suicide Prevention

Learning Module 2: Describing the Problem and its Context

Know the Signs >> Find the Words >> Reach Out

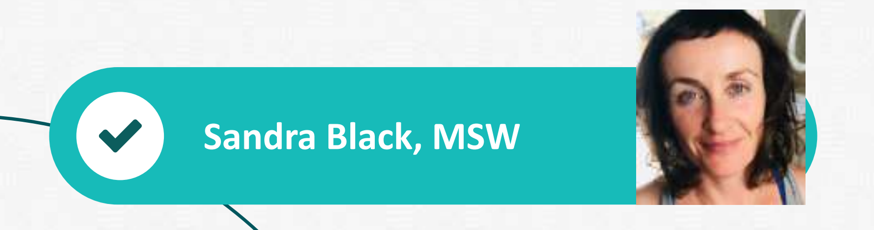
Funded by counties through the voter-approved Mental Health Services Act (Prop. 63).

- If you called in on the phone, find and enter your audio PIN
- If you have a question, technical problem or comment, please type it into the "chat" box or use the icon to raise your hand.

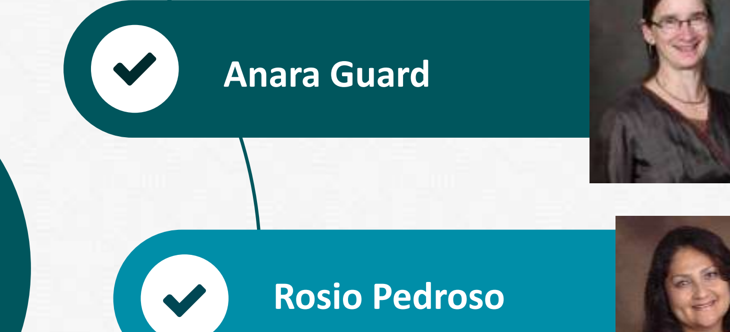


Sandra Black has worked in suicide prevention in California since 2007. Until 2011 she managed the California Office of Suicide Prevention, which included completion and implementation of the California Strategic Plan on Suicide Prevention. In 2011 she joined the Know the Signs suicide prevention social marketing campaign as a consultant, and has since also joined the Each Mind Matters mental health movement team. She provides technical assistance to counties and community-based organizations around mental health promotion and suicide prevention. She holds an MSW from the University of California, Berkeley and a BS from Cornell University.

Anara Guard has worked in suicide and injury prevention since 1993. For the past eight years, she has been a subject matter expert advising Know the Signs and other suicide prevention projects. Previously, she was deputy director at the national Suicide Prevention Resource Center where, among other duties, she led the development of annual grantee meetings for SAMHSA's suicide prevention grantees and oversaw technical assistance. She has presented numerous workshops and trainings for journalists, community members, and the field of suicide prevention at large on how best to communicate about suicide prevention. Her publications include peer-reviewed articles and manuals on alcohol screening and brief intervention, rural suicide postvention, consumer protection approaches to firearm safety, child hyperthermia, violence and teen pregnancy, and more. Ms. Guard earned a master's degree in library and information science and a certificate in maternal and child health.



Sandra Black, MSW



Anara Guard

Rosio Pedroso

Stan Collins

Jana Sczersputowski, MPH

Rosio Pedroso has over 20 years of research and evaluation experience focusing on unserved and underserved communities. She has over six years of experience conducting train the trainer curriculum and materials for community engagement and statewide campaigns including suicide prevention and child abuse and neglect awareness.

Stan Collins, has worked in the field of suicide prevention for nearly 20 years. Currently he is working as a consultant, focusing on technical assistance in creation and implementation of suicide prevention curricula and strategies. Stan is a member of the American Association of Suicidology's Communication team and in this role supports local agencies in their communications and media relations related to suicide. In addition, he is specialized in suicide prevention strategies for youth and in law enforcement and primary care settings. Since 2016 he has been supporting school districts with AB 2246 policy planning and as well as postvention planning and crisis support after a suicide loss or attempt.

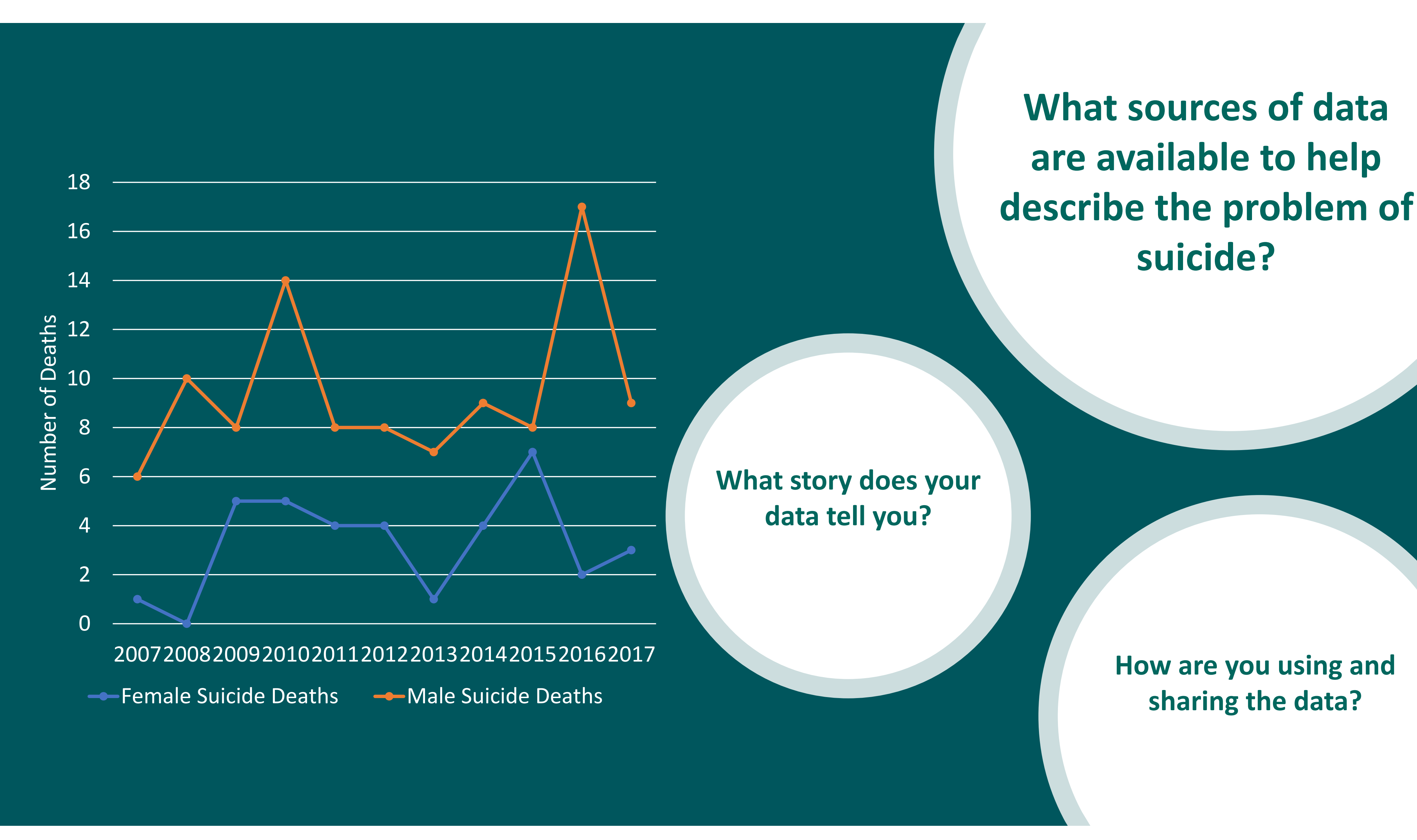
Jana Sczersputowski applies her public health background to deliver community-driven and behavior change oriented communication solutions in the areas of mental health, suicide prevention, child abuse prevention and other public health matters. She is specialized in strategic planning, putting planning into action, and evaluating outcomes. Most of all she is passionate about listening to youth, stakeholders and community members and ensuring their voice is at the forefront of public health decision making impacting their communities.

Strategic Planning Learning Collaborative Overview

Webinar 2: Describe the Problem and its Context

- **Tuesday December 4 10:30am-12p**

- Webinar 1: Strategic Planning Framework
  - **November 6th 10:30am-12pm**
  - **Recording Link:** https://attendee.gotowebinar.com/recording/2093205551616896003
- Webinar 3: Building and sustaining a coalition
  - **January 15th 10:30am-12pm**
- Webinar 4: Putting planning into action: Selecting interventions and using logic models
  - **February 5th 10:30am-12pm**
- Webinar 5: Evaluating and sustaining your efforts
  - **March 12th 10:30am-12pm**



What sources of data are available to help describe the problem of suicide?
What story does your data tell you?
How are you using and sharing the data?
Number of Deaths
18
16
14
12
10
8
6
4
2
0
2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017
Female Suicide Deaths
Male Suicide Deaths

- Provide context to local issue of suicide
- Dispel misconceptions
- Focus effort where the problem is most severe
- Identify risk and protective factors to select interventions
- Persuade funders, policy and decision makers
- Evaluation and measuring change over time

Telling a story about suicide and suicide prevention

- Mortality
- Morbidity
- Co-morbidity
- Risk and protective factors
- Help seeking
- Qualitative data
    - Community strengths and gaps
    - Existing resources and programs

Mortality

deaths that were confirmed to be suicide.

Sources	What it tells you
Coroner	Who dies by suicide Means of suicide Risk factors
EpiCenter (CA DPH)	State and county Numbers, rates, means All ages & demographics Can create queries
Death Review Teams	Demographics and means Warning signs Risk factors and context
CDPH County Health Status Profiles	State and county Rates, 3-year averages, percentages Ranked and compared to national Healthy People 2020 objectives All ages & demographics Data grouped into annual reports

Outcome: Death
Non-fatal Hospitalization
Non-fatal Emergency Department Visit (treat & release, or transfer to another facility)

Show Crude Rates
Population data based on 2010 Census estimates. See Help.

Year: From 1991 through 2016

ounty of Residence: California
Alameda
Alpine
Amador

If selecting multiple counties, hold down the Control key (

Race/Ethnicity: All Race/Ethnicity
White
Black
Hispanic

If selecting multiple race/ethnicity groups, hold down the

Age: All Ages
Custom Age Range
From Age: through Age: years old (Enter "0" to capture those <

Cause Group: All injuries
All unintentional injuries
All self-inflicted injuries
All assault injuries

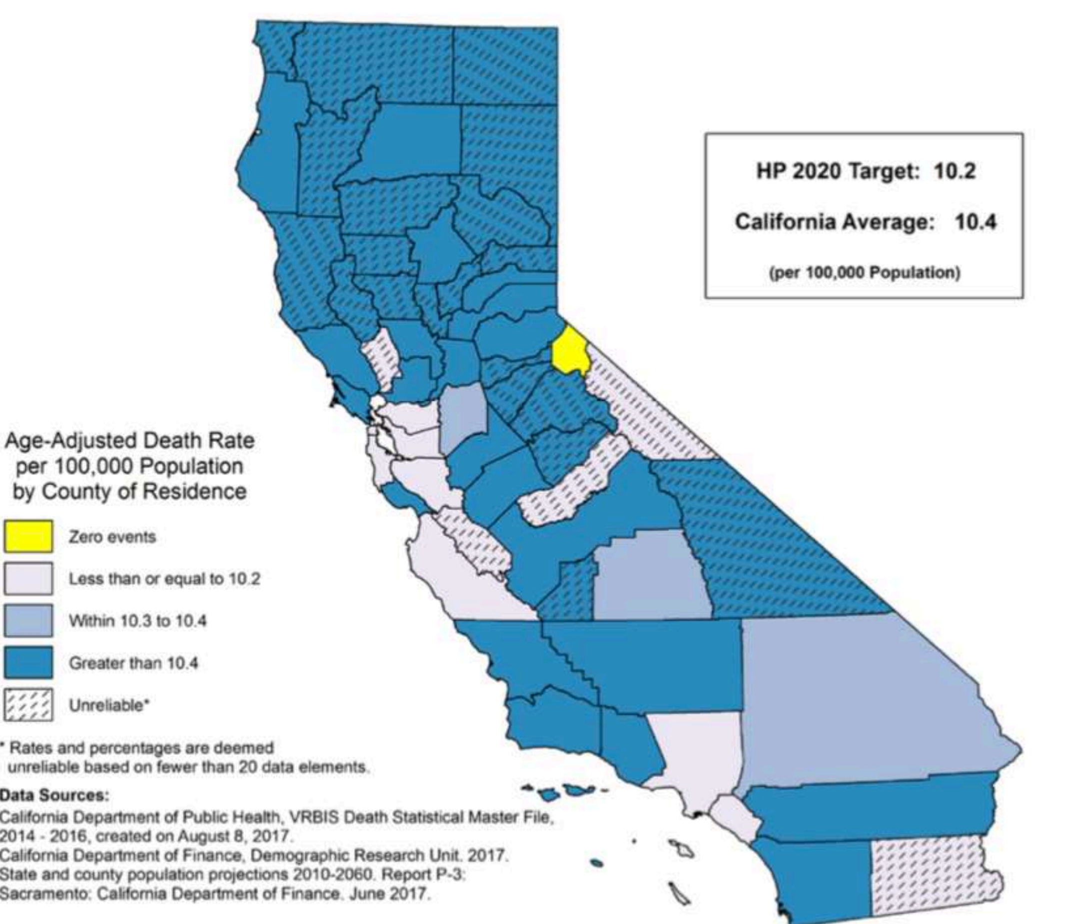
If selecting multiple causes of ir
Mac users).

Additional Detail

Select up to four options for more detailed tables, e.g., by sex, age, etc.

First level of detail
✓ Age (summary age groups: < 1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-44, 45-64, 65-84, 85+)
Age (single year: 0, 1, 2, 3, etc.)
Age (5-year groups: 0-4, 5-9, etc.)
County of residence
Education level (available for year 2003+ and age 25+)
Race/ethnicity
Sex
Veteran status (available for year 2005+ and age 18+)
Cause of injury
Cause of injury (ICD-9/ICD-10 codes)
Intent
Year
Month of Death (available for year 2005+)

DEATHS DUE TO SUICIDE, 2014-2016



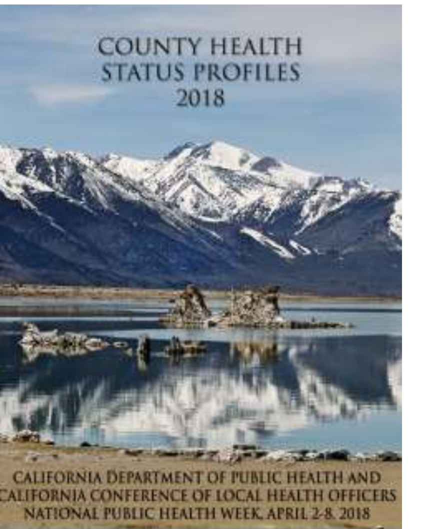
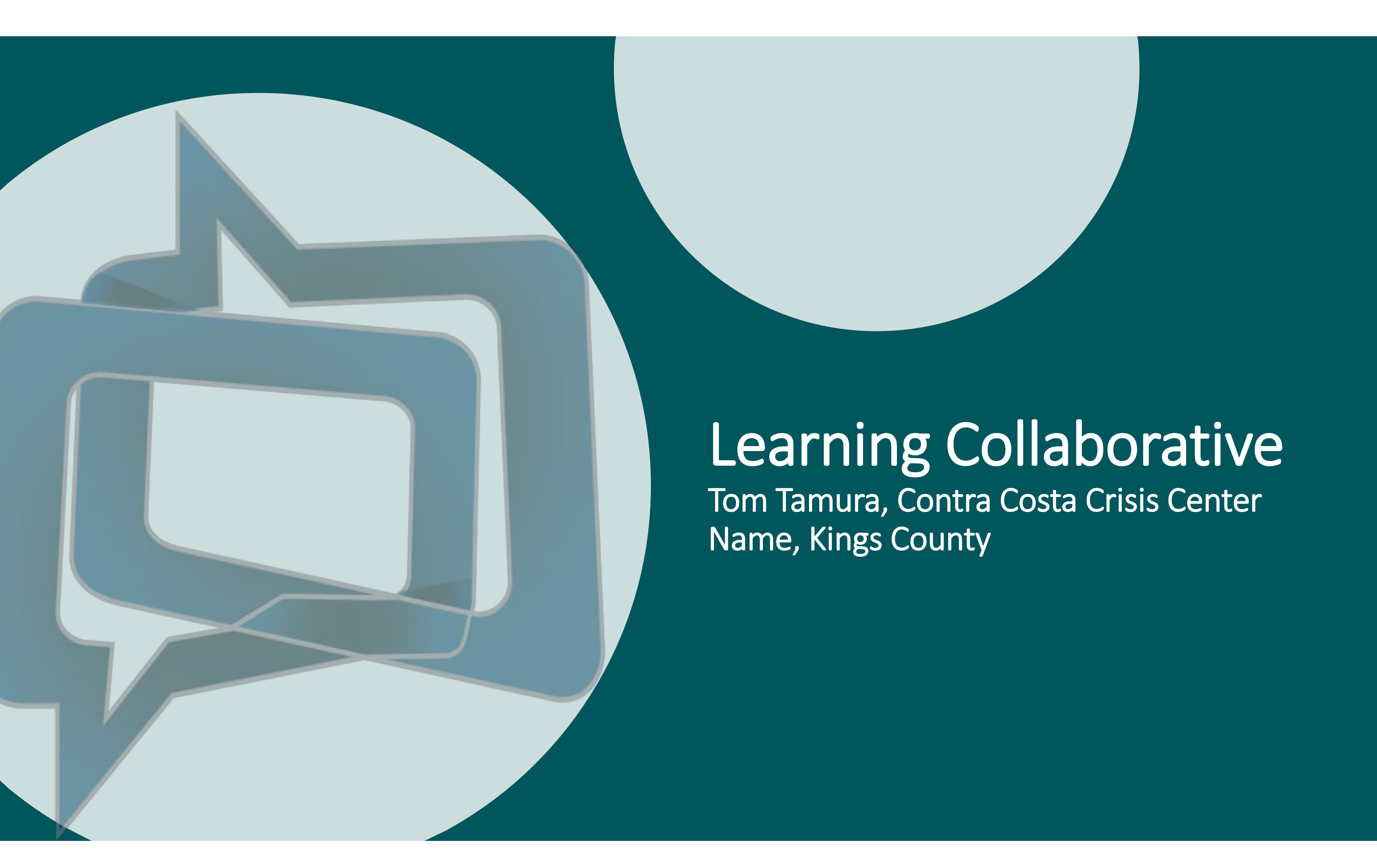


TABLE 16
DEATHS DUE TO SUICIDE
RANKED BY THREE-YEAR AVERAGE AGE-ADJUSTED DEATH RATE
CALIFORNIA COUNTIES, 2014-2016

COUNTY ‹F RESIDENCE	2015 POPULATION	2014-2016 DEATHS (AVERAGE)	CRUDE DEATH RATE	AGE-ADJUSTED DEATH RATE	95% CON LOWE
NE	1,157	0.0	-	-	
O	13,818	0.3	2.4 *	4.7 *	
MATEO	764,379	60.0	7.8	7.4	
BENITO	57,584	4.0	6.9 *	7.4 *	
TA CLARA	1,915,102	151.7	7.9	7.6	
ANGELES	10,185,487	817.7	8.0	7.8	
ERIAL	185,328	14.7	7.9 *	8.1 *	
MEDA	1,619,679	154.7	9.5	9.0	
A	141,546	14.7	10.4 *	9.5 *	
ERA	154,956	14.7	9.5 *	9.6 *	
NGE	3,161,218	321.7	10.2	9.6	
FRANCISCO	863,108	94.7	11.0	9.8	
TRA COSTA	1,116,882	118.3	10.6	10.0	
TEREY	436,242	45.0	10.3	10.2	
HEALTHY PEOPLE 2020 NATIONAL OBJECTIVE: MHMD-1				10.2	
ARE	463,291	45.3	9.8	10.4	
BERNARDINO	2,129,851	212.0	10.0	10.4	
JOAQUIN	727,547	74.0	10.2	10.4	
FORNIA	**39,059,809**	**4,187.0**	**10.7**	**10.4**	**1**
S	149,702	14.7	9.8 *	10.7 *	
RSIDE	2,329,256	254.0	10.9	10.8	
NISLAUS	538,372	58.0	10.8	10.8	
TURA	852,013	97.3	11.4	10.9	
SNO	979,357	101.7	10.4	11.1	


Learning Collaborative
Tom Tamura, Contra Costa Crisis Center
Name, Kings County

Morbidity

non-fatal, intentional self injuries, or suicide attempts. They exclude accidental self injury.

Co-Morbidity

risk factors that are related to the suicidal behavior.

Sources	What it tells you
Local hospitals EpiCenter (CA DPH)	Non-fatal self injuries treated in hospitals and emergency rooms State and county Non-fatal & fatal injuries by method All ages & demographics Can create queries
CDC WISQARS	Non-fatal self injuries treated in hospitals and emergency rooms State and county Non-fatal self-inflicted injuries & method All ages and demographics Cost of injury reports Can create queries
CDC Behavioral Risk Factor Surveillance System (BRFSS)	Phone surveys Adults 18+ Associated risk factors such as substance use, mental health conditions

Outcome:
- Death
- Non-fatal Hospitalization
- Non-fatal Emergency Department Visit (treat & release, or transfer to another facility)

Show Crude Rates
Population data based on 2010 Census estimates. See Help.

Year: From 2014 through 2014

County of Residence: Monterey, Napa, Nevada, Orange — If selecting multiple counties, hold down the Control key (Mac key for Mac users).

Race/Ethnicity: All Race/Ethnicity, White, Black, Hispanic — If selecting multiple race/ethnicity groups, hold down the Control key (Mac key for Mac users).

Age:
- All Ages
- Custom Age Range

From Age: through Age: years old (Enter "0" to capture t

Cause Group: All injuries, All unintentional injuries, All self-inflicted injuries, All assault injuries — If selecting multiple cau the Control key (Mac ke

Specific Cause: Enter ICD9 or 10 codes for the causes you want (e.g., 8900, 894, V1 codes override any Cause Group selected above.

First level of detail
- Age (summary age groups: < 1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-44, 45-64, 65-84, 85+)
- Age (single year: 0, 1, 2, 3, etc.)
- Age (5-year groups: 0-4, 5-9, etc.)
- County of residence
- Race/ethnicity
- Sex
- Primary diagnosis (Nature of injury)
- Primary diagnosis (Body part injured)
- Disposition on discharge
- Expected source of payment
- Cause of injury
- Cause of injury (ICD-9 E-Codes)
- Intent
- Year
- Month of Admission (available for year 2005+)
- Day of Week of Admission (available for year 2005+)

Suicidal Thoughts
(self reported)

Sources	What it tells you
CDC Youth Risk Behavior Surveillance	National and state Suicidal ideation Suicide attempts 9th-12th grade students
CA Healthy Kids Survey	Modular survey (administered at schools) California, biannual Students age 10 and up Mental health and resiliency Risk and protective factors
SAMHSA National Survey on Drug Use & Health	Interviews Youth ages 12-17, Adults 18+ National and state Suicidal ideation, suicide attempts Substance use Mental illness
CA Health Interview Survey	Biannual phone survey State, regional, county Suicide Ideation (adults only) Adults 18+, adolescents (12-17), child (0-11)

Annual National Report

Key Substance Use and Mental Health Indicators in the United States

The 2017 Key Substance Use and Mental Health Indicators report summarizes the following:

- Substance use (alcohol, tobacco, marijuana, cocaine, heroin, hallucinogens, and inhalants, as well as the misuse of opioids, prescription pain relievers, tranquilizers, stimulants, and sedatives)
- Initiation of substance use
- Perceived risk from substance use
- Substance use disorders
- Any mental illness, serious mental illness, and major depressive episode
- Suicidal thoughts, plans, and non-fatal attempts for adults ages 18 or older
- Substance use treatment and mental health service use

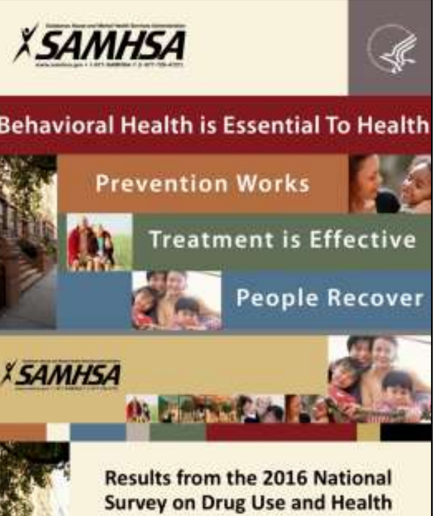


Table 19 – Selected Drug Use, Perceptions of Great Risk, Past Year Substance Use Disorder and Treatment, and Past Year Mental Health Measures in *California*, by Age Group: Estimated Numbers (in Thousands), Annual Averages Based on 2015-2016 NSDUHs

Measure	12+	12-17	18-25	26+	18+
PAST YEAR MENTAL HEALTH ISSUES					
Serious Mental Illness[4,11]	--	--	222	845	1,068
Any Mental Illness[4,11]	--	--	977	4,095	5,072
Received Mental Health Services[12]	--	--	418	3,009	3,427
Had Serious Thoughts of Suicide[13]	--	--	376	797	1,173
Major Depressive Episode[4,14]	--	393	468	1,318	1,786

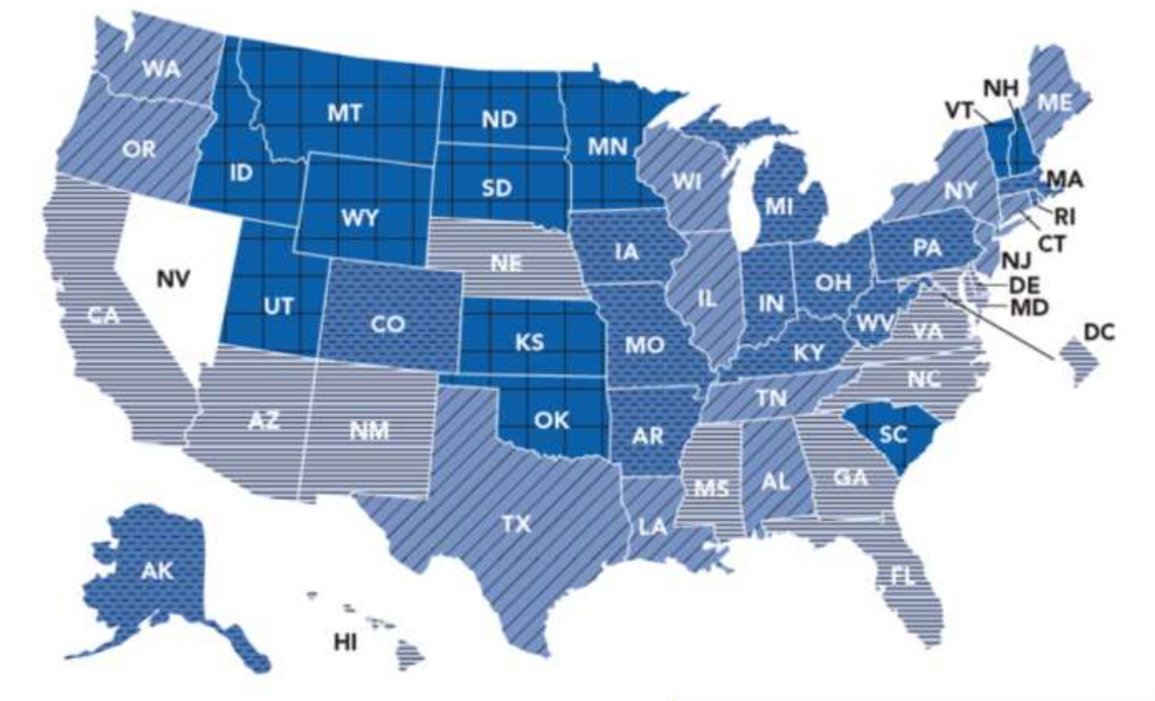
Risk and Protective Factors

Sources	What it tells you
National Violent Death Reporting System California Violent Death Reporting System (EpiCenter)	All ages and demographics State, county Range of factors and circumstances surrounding deaths
Coroner/Medical Examiner Reports	Details surrounding the circumstances of individual deaths based on investigation
Local stakeholder Interviews, Surveys and Assessments	Perceived problem of suicide in the community Available and missing programs and services

Suicide rates rose across the US from 1999 to 2016.

Legend	Range
Increase	38 - 58%
Increase	31 - 37%
Increase	19 - 30%
Increase	6 - 18%
Decrease	1%

SOURCE: *CDC's National Vital Statistics System; CDC Vital Signs, June 2018.*



Vital Signs

Suicide rising across the US

More than a mental health concern

Many factors contribute to suicide among those with and without known mental health conditions.

Relationship problem **(42%)**

Problematic substance use **(28%)**

Crisis in the past or upcoming two weeks **(29%)**

Job/Financial problem **(16%)**

Physical health problem **(22%)**

Loss of housing **(4%)**

Criminal legal problem **(9%)**

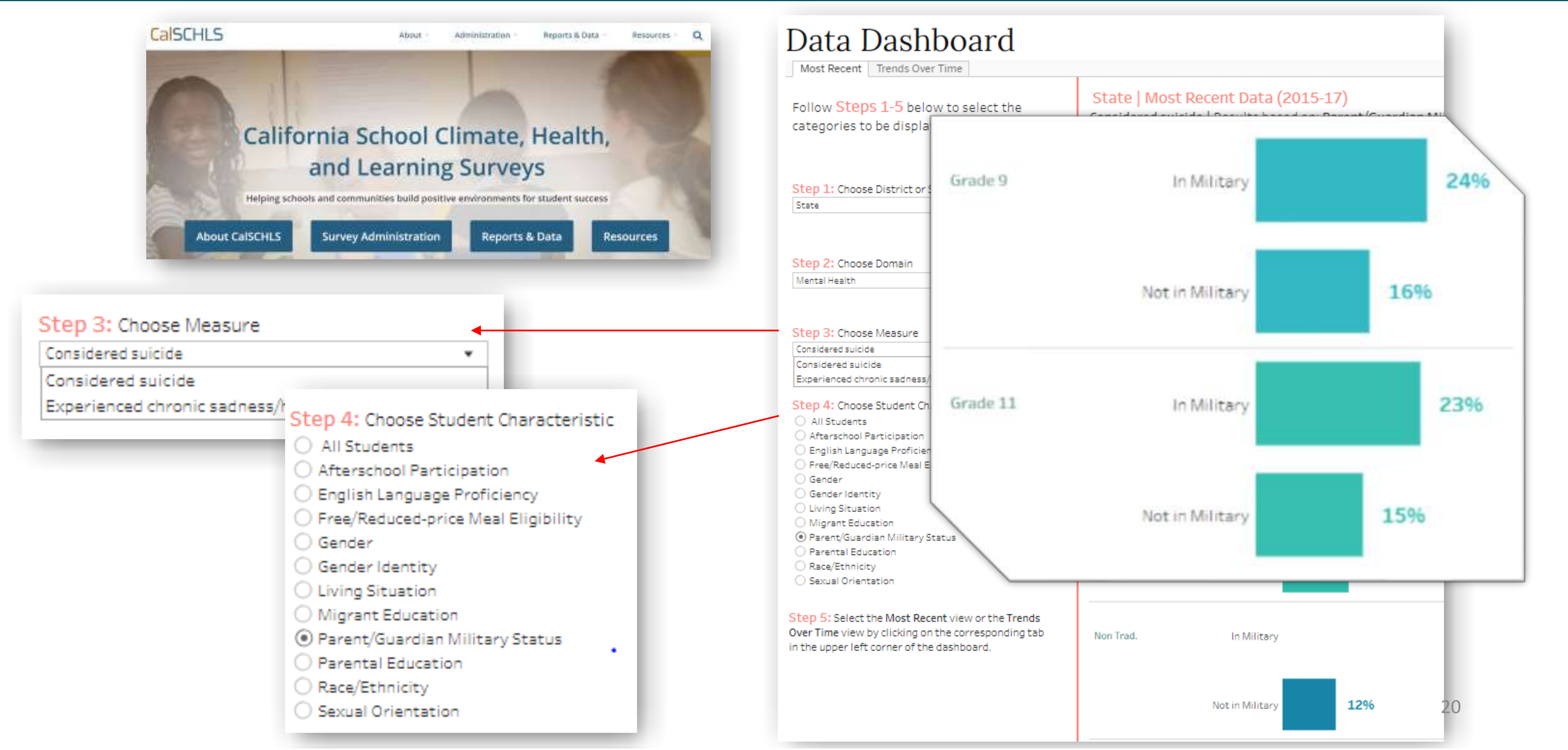
Note: Persons who died by suicide may have had multiple circumstances. Data on mental health conditions and other factors are from coroner/medical examiner and law enforcement reports. It is possible that mental health conditions or other circumstances could have been present and not diagnosed, known, or reported.

SOURCE: *CDC's National Violent Death Reporting System, data from 27 states participating in 2015.*

54%.

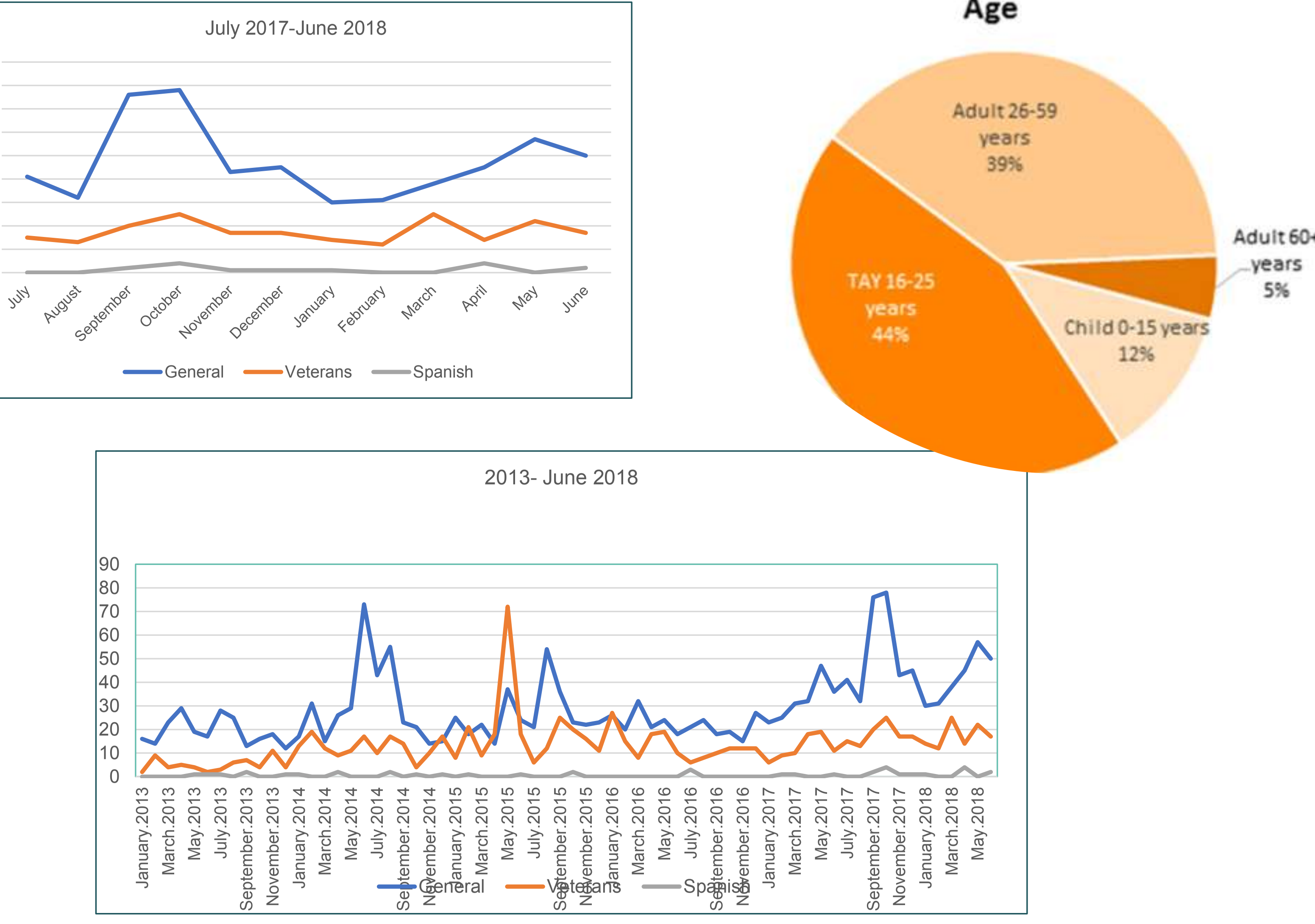
More than half of people who died by suicide did not have a known mental health condition.

California Healthy Kids Survey (calschls.org)



Help Seeking & Prevention

Type of Data	Sources	What it tells you
Help Seeking	National Suicide Prevention Lifeline	Number of calls that originated in your county Calls to Spanish Hotline Calls to Veteran Hotline
	Local hotline data Warm line data Friendship Line Trevor Project Poison Control System Behavioral Health Dept	Number and demographics of people calling Service usage
Trainings	Local providers	Number of trainings provided Number of people trained
Help Seeking System Mapping	Local partners	How are people connected to help in various settings (school, primary care, law enforcement, other)


July 2017-June 2018
90
80
70
60
50
40
30
20
10
0
July
August
September
October
November
December
January
February
March
April
May
June
General
Veterans
Spanish
Age
Adult 26-59 years 39%
Adult 60+ years 5%
Child 0-15 years 12%
TAY 16-25 years 44%
2013- June 2018
90
80
70
60
50
40
30
20
10
0
January.2013
March.2013
May.2013
July.2013
September.2013
November.2013
January.2014
March.2014
May.2014
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January.2017
March.2017
May.2017
July.2017
September.2017
November.2017
January.2018
March.2018
May.2018
General
Veterans
Spanish

Public Health Surveillance

Continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice.

Surveillance can:

- serve as an **early warning system** for impending public health emergencies;
- **document the impact** of an intervention, or **track progress** towards specified goals;
- **monitor and clarify** the epidemiology of health problems, to allow priorities to be set and to inform public health policy and strategies.

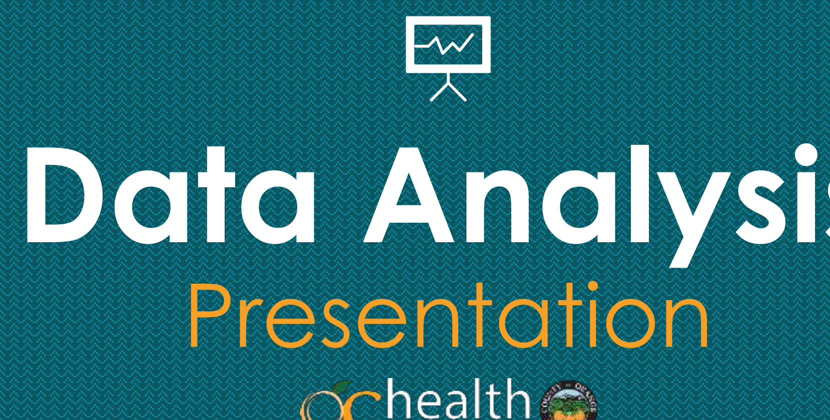
Setting up a Surveillance System

- Identify data sources at multiple levels
- Establish partnerships with those agencies/systems/organizations to ensure regular access
- Establish a process for how the data will be regularly reviewed, and how it will be incorporated into planning and evaluation
- Compile data into reports or presentations that can be shared with stakeholders and others as needed

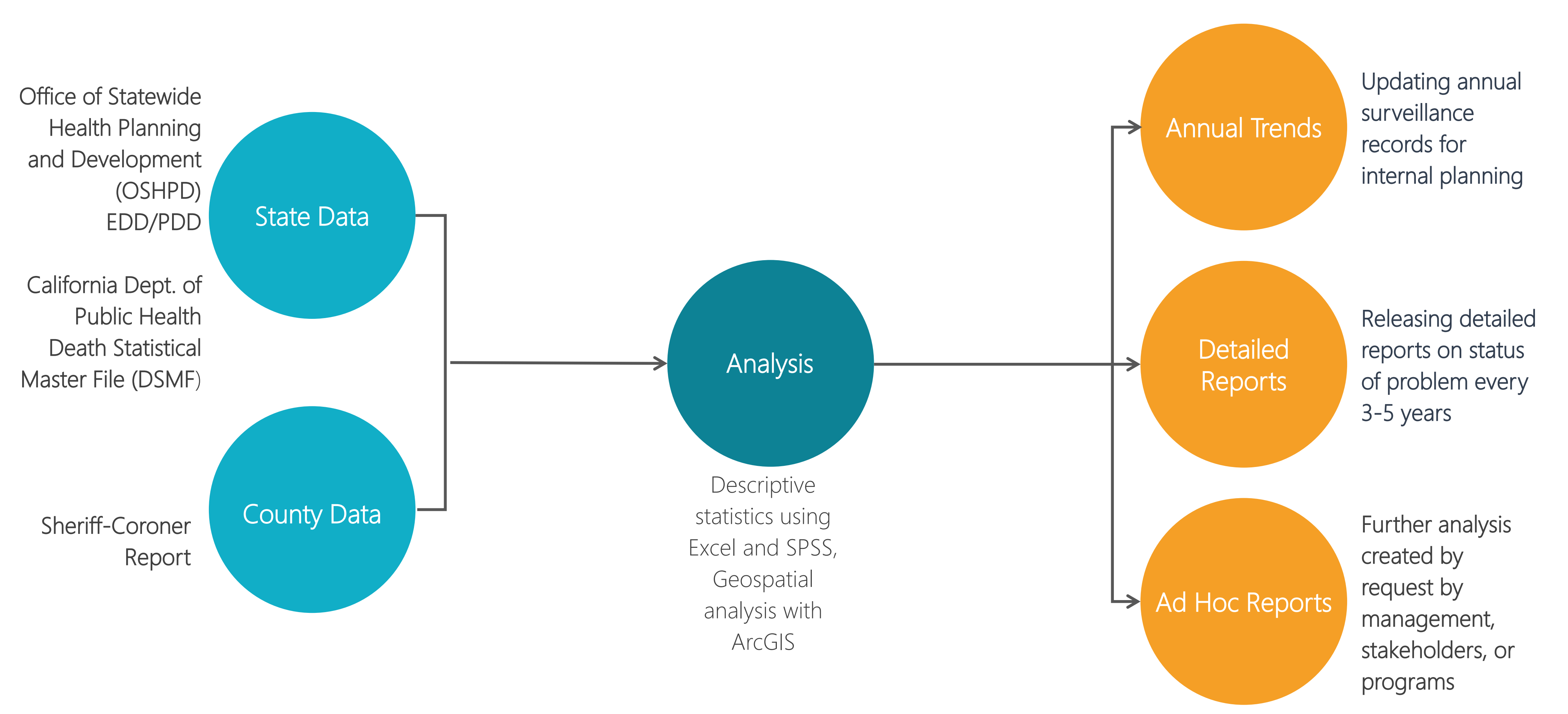
Q&A

Data Analysis

Presentation

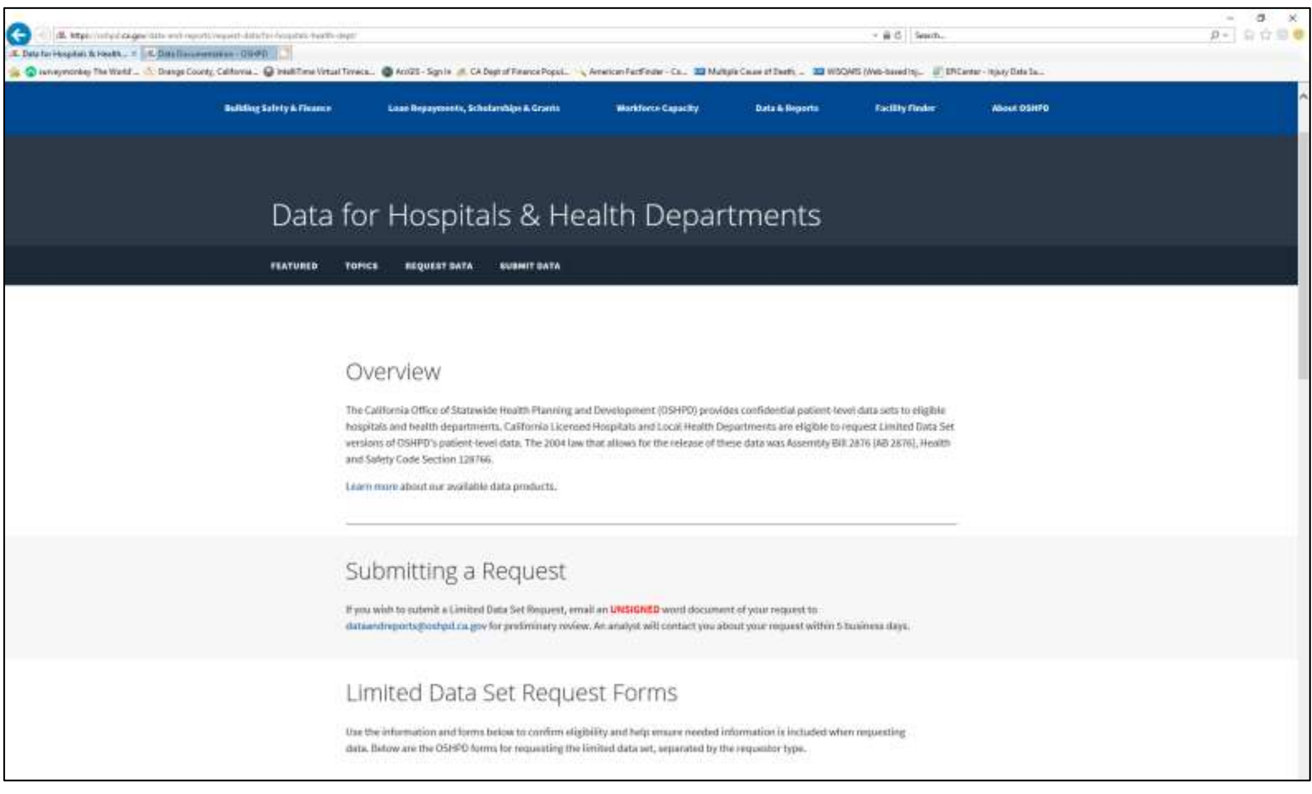


Data Analysis



Data Analysis

Requesting Data



Primarily, surveillance data arrives from the California Department of Public Health.

All local governments in CA can request the data, following the instructions here:

Deaths (CDPH DSMF): https://www.cdph.ca.gov/Programs/CHSI/Pages/Data-Applications.aspx *

Emergency Department Visits and Hospitalizations (OSHPD EDD/PDD): https://oshpd.ca.gov/data-and-reports/request-data/for-hospitals-health-dept/

*Births and death data now available from the CDPH online California Integrated Vital Records System https://casadm.calivrs.org/cas-server/login?service=https%3A%2F%2Fvrbis.calivrs.org%2Fvrbis-web-static%2Flogin%2Fcas

Data Analysis

Information Available

Diagnosis, Injury, Disease, Cause of Death:
Usually in ICD-9-CM or ICD-10-CM form

Demographics:
Gender, Race/Ethnicity, Age and sometimes other variables like nationality, primary language, education, etc.

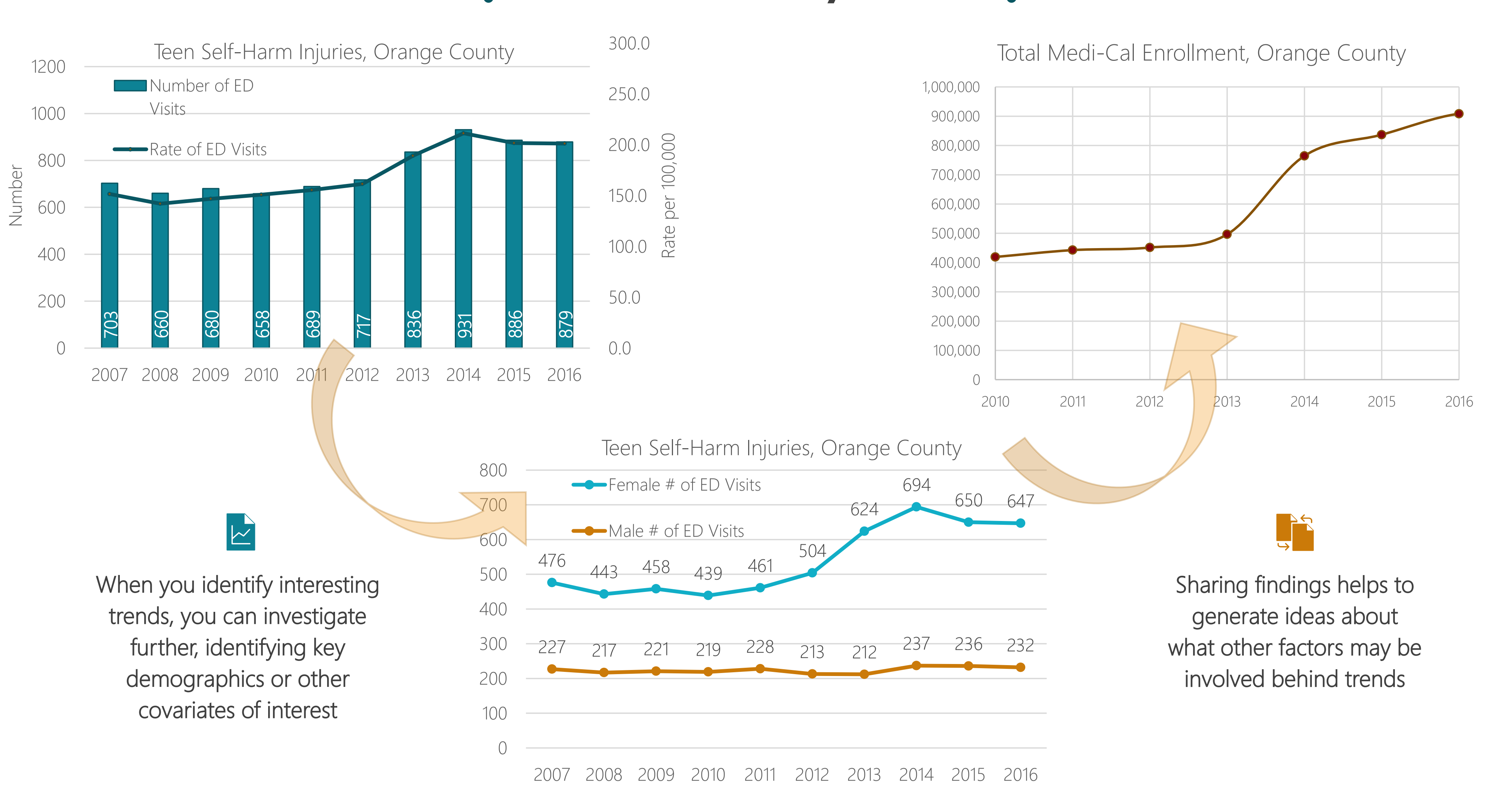
Geography:
Location information can be exact as an address, ZIP code or more broad, such as county of residence

Depending on the data source, other variables are available such as payer/insurance, additional diagnoses and procedure codes, place of injury, etc.

Data Analysis

	PRO	CON
OSHPD Data	> Most detailed case data for morbidity > Based on Emergency Department Encounters (EDD) and Hospitalizations (PDD) Data > Includes some important co-variables, like age and race	> Location only specific to zip code level > Socio-economic variables not included > Reporting lag up to 1.5 years
DSMF Data	> More detailed demographics compared to OSHPD > Cause of death coded as ICD-9 or 10-CM > Location specific to address of residence	> More specific socio-economic variables not included > Reporting lag up to nearly 1.5 years
Sheriff-Coroner	> Detailed text to explain cause of death > Less lag-time in reporting	> Not uniformly coded/more difficult to analyze with syntax or on large scale

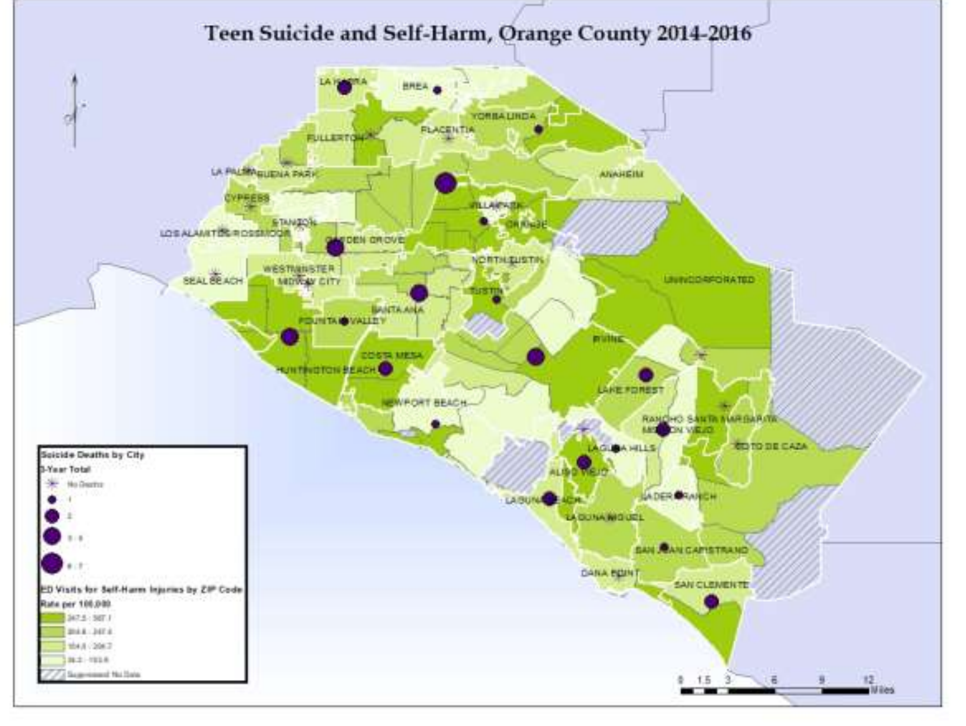
Data Analysis



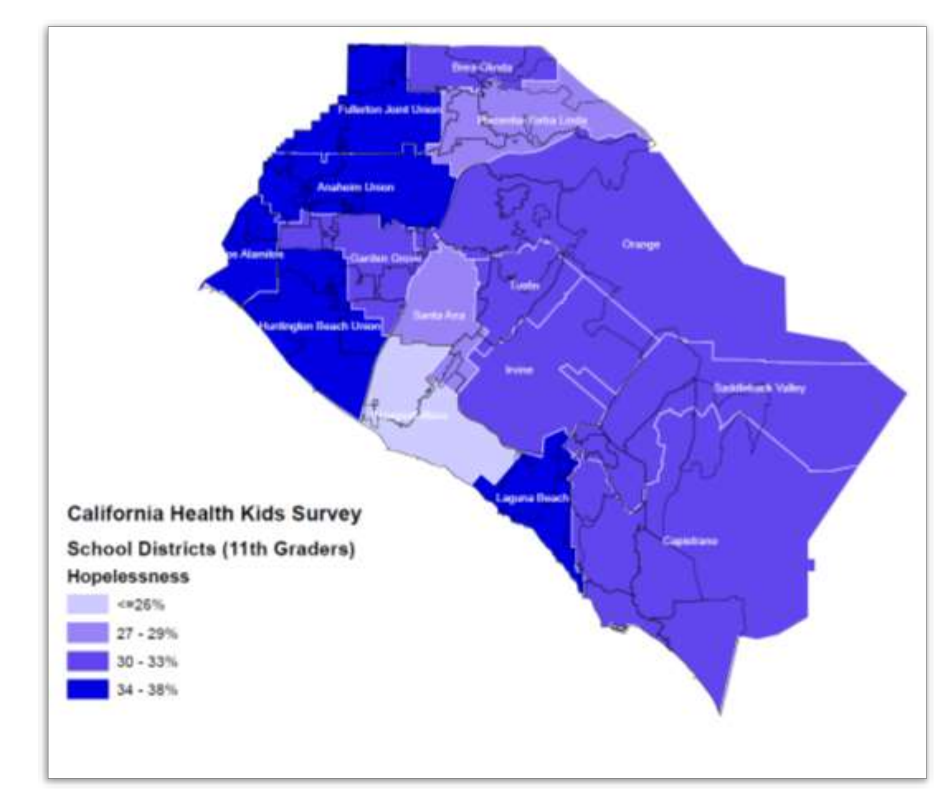
When you identify interesting trends, you can investigate further, identifying key demographics or other covariates of interest

Sharing findings helps to generate ideas about what other factors may be involved behind trends

Data Analysis



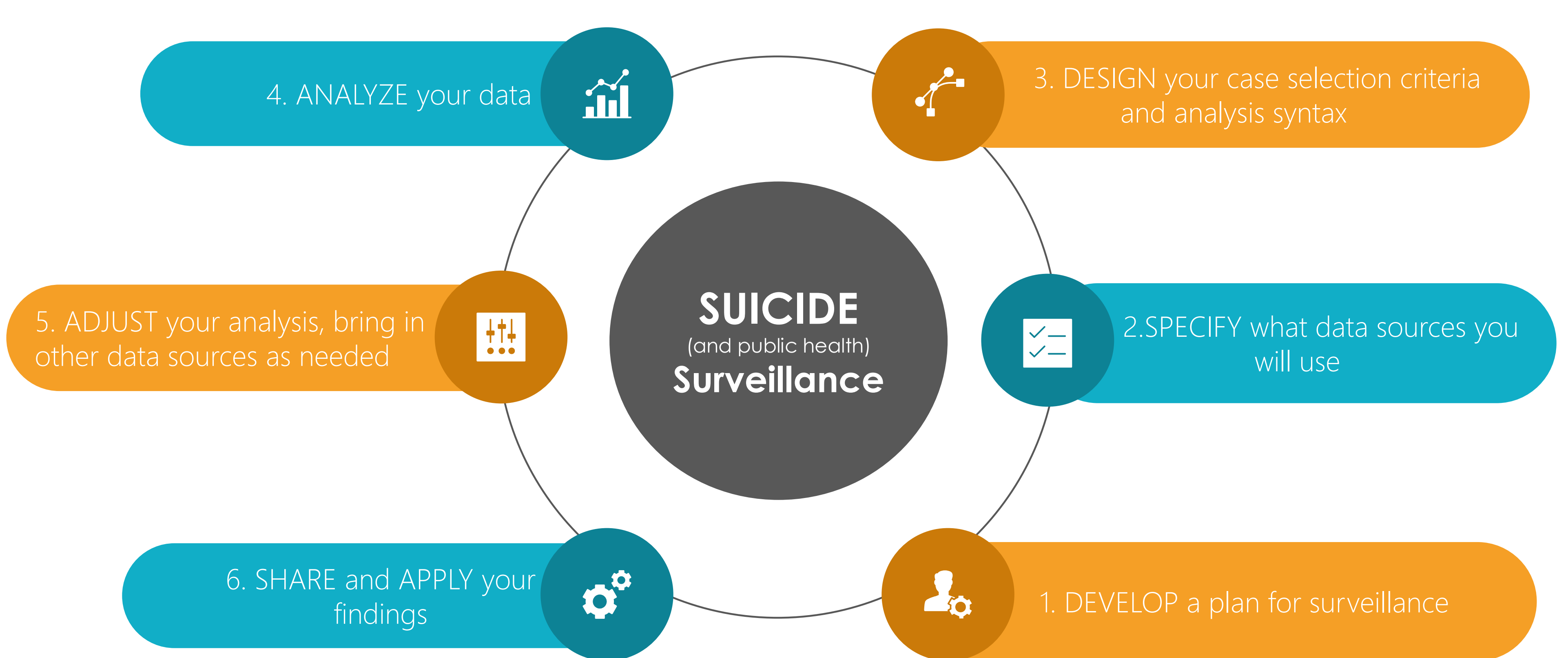
GEOGRAPHIC ANALYSIS USING ARCMAP



ANALYZING DATA BY GEOGRAPHY helps to visualize data and communicate where resources should be targeted.

Data Analysis

In Summary



Thank You

Child Death Review Teams

ICAN Inter-Agency Public Private Partnership

In 1977, the Los Angeles County Board of Supervisors designated the Inter- Agency Council on Child Abuse and Neglect (ICAN) as the official LA County agent to coordinate services for the prevention and treatment of child abuse and neglect.

ICAN National Center on Child Fatality Review

In 1996, ICAN Associates, Inc. received a grant from the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, to establish the ICAN National Center on Child Fatality Review (NCFR). The mission of NCFR is to develop and promote a nationwide system of Child Fatality Review Teams to improve the health, safety and well being of children and reduce preventable child fatalities and severe injuries

Child and Adolescent Suicide Review Team (CASRT)

In 2001, a multi-disciplinary sub-group of the ICAN Child Death Review Team, the Child and Adolescent Suicide Review Team (CASRT) was formed. The Team reviews child and adolescent suicides, analyzes trends and makes recommendations aimed at the recognition and prevention of suicide and suicidal behaviors.

Teams Include Representatives From The Following

Los Angeles County Departments

- Children and Family Services
- Commission/Housing
- Community Development
- County Counsel
- District Attorney
- County Fire
- Health Services
- Medical Examiner-Coroner
- Medical Hubs
- Mental Health
- Office of Education
- Probation
- Probation
- Public Defender
- Public Health
- Public Social Services
- Sheriff

City of Los Angeles

- Los Angeles Police Department
- Los Angeles Fire Department
- Los Angeles Unified School District
- Office of City Attorney

State and Other Community Partners

- Almansor Center
- Burbank United School District
- Chicago School of Professional Psychology
- Children's Hospital of Los Angeles
- Community Care Licensing
- Community Child Abuse Councils
- Edelman Children's Court
- Independent Police Agencies
- Pacific Clinics
- United American Indian Movement
- USC School of Medicine
- Whittier-Union School District

Child and Adolescent Suicides 2016

Table 19

Five Year Trend by Age

Age	2012	2013	2014	2015	2016	Total	%
17 years	7	4	1	9	5	26	33.8%
16 years	3	4	2	6	1	16	20.7%
15 years	5	2	0	1	3	11	14.3%
14 years	2	1	3	4	3	13	16.9%
13 years	0	1	2	3	2	8	10.4%
12 years	0	0	1	0.	0	1	1.3%
11 years	0	1	1	0	0	2	2.6%
Total	17	13	10	23	14	77	100%

Child and Adolescent Suicides 2016

Table 17

Child and Adolescent Suicides by Method and Gender, Los Angeles County - 2016 (N = 14)

Method	Male	Female
Hanging	6	4
Firearms/Gunshot	2	0
Jump from height	1	0
Overdose	1	0
TOTAL	10	4

Table 18

Five Year Suicide Trend-Gender

Gender	2012	2013	2014	2015	2016	Total 2011-2015	5 Year Average
Male	8	5	6	14	10	43	8.6
Female	9	8	4	9	4	34	6.8
Total	17	13	10	23	14	77	15.4

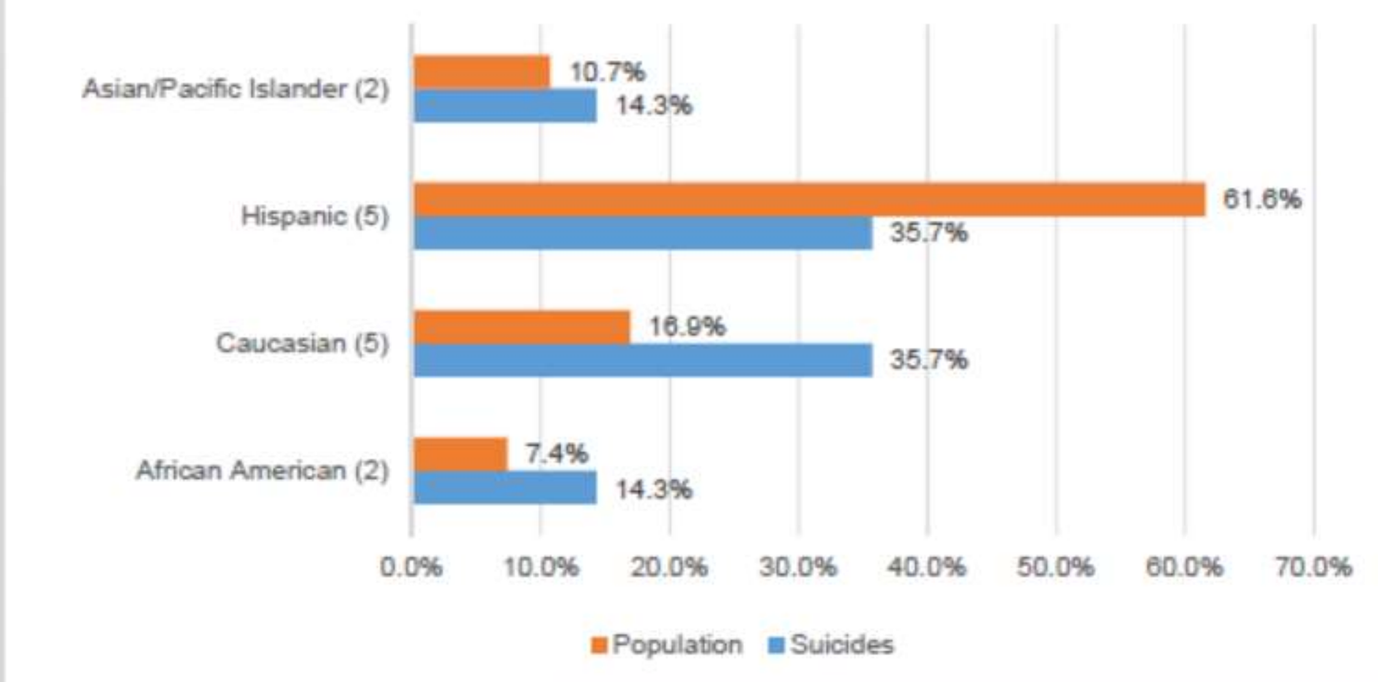


Figure 10: Suicides of Children by Race Compared to General Population - 2016
Asian/Pacific Islander (2)
10.7%
14.3%
Hispanic (5)
61.6%
35.7%
Caucasian (5)
16.9%
35.7%
African American (2)
7.4%
14.3%
0.0%
10.0%
20.0%
30.0%
40.0%
50.0%
60.0%
70.0%
Population
Suicides

Child and Adolescent Suicides 2016

Figure 12: Percentage of Child and Adolescent Suicide Victim Factors

Child had academic problems (4)
29%
School discipline/trauncy problems (1)
7%
Family history of CPS or Probation (5)
36%
Child experienced bullying (2)
14%
Child LGBT questioning (1)
7%
History of an eating/body image disorder (2)
14%
History of substance use (2)
14%
Disfunctional family dynamics time of death (4)
29%
Child had recent relationship loss or conflict (10)
71%
Child in therapy/counseling (5)
36%
Child on psychotropic medication (5)
36%
Child had prior psychiatric hospitalizations (3)
21%
Child had a mental health diagnosis (7)
50%
History of self-injury or cutting (4)
29%
Child texted suicide intent (2)
14%
Child left suicide note (4)
29%
Exhibited warning signs (9)
64%
Prior suicide attempts (4)
29%
0%
20%
40%
60%
80%

APPENDIX A - ICAN Youth Suicide Coroner/Medical Examiner Procedural Guide

ICAN Youth Suicide Coroner/Medical Examiner Investigation Procedural Guide

Language Interviewed in: ☐ English ☐ Other ___________
Translated by: ___________

Case Number: ___________
Decedent: ___________
DOD: ___/___/___ Date of Interview: ___/___/___
Investigator: ___________

(Do not release with copy of Autopsy Report)

Mental Health

Recent Mental Health, Substance Abuse/Dependency Treatment History < 2 months *(Acute)* *i.e. diagnosis, outpatient therapy, hospitalization, detox, rehab., recent sobriety*

Mental Health, Substance Abuse/Dependency TX History > 2 months *(Chronic)* *i.e. diagnosis, outpatient therapy, hospitalization, detox, rehab*

Presence of Trigger Events <2 months *(Acute)* *i.e. actual/anticipated loss of relationship, conflict with parents, conflict with school/job or other authorities, court appearance*

Prescribed Medication *i.e. compliance, recent change, psychotropic medication*

Self-Injurious/Risk-Taking Behavior *i.e. substance use/abuse, cutting and burning, auto-erotic asphyxiation, alcohol use/abuse, "choking game", "Russian Roulette"*

Mental Health

Depression and Other Psychological Symptoms *i.e. impaired mental status, perceived burdensomeness, perceived pain, stress, agitation, hopelessness, self-hate, worthlessness, depressed mood, anxiety/panic, anger, anhedonia, guilt, impulsivity, poor reality testing, sleep/eating disturbances, command hallucinations, intoxication, aggressive tendencies, recent changes in behavior, recklessness.*

Acute <2 months	Chronic >2 months

Suicide Exposure & Behavior

Prior Suicide Attempts *(indicate dates, times, methods, medical care needed)*

Exposure to Others' Behavior *i.e. completed Suicides or attempts of family, friends or role models*

Discussion of Suicide, and Notes *i.e. verbal, written or online/electronic thoughts communicated to family, peers, teachers, post-mortem messages left for family, peers, teachers*

Access to Lethal Means

When appropriate *(indicate information about secure access to weapons, such as firearms, medication, etc. Did the decedent have familiarity with weapon? Parental supervision? Were the weapons secured - Firearm locked in storage cabinet? Ammunition kept separate or firearm kept loaded?*

Funding for the *ICAN CORONER SUICIDE GUIDELINES* was provided in part by the *JEFFREY GUTIN FUND FOR YOUNG ADULTS* of the New Hampshire Charitable Foundation

Scan and Email this form and completed Report to Tom Fraser at frasert@dcfs.lacounty.gov

Medical

Physician or Clinic Visits within last 12 months *(specify physical and psychological complaints, conditions affecting activities of daily living)*

Emergency Department Visits within the last 2 Months *(specify physical and psychological complaints)*

Hospitalizations within the last 12 Months *(indicate dates, duration, diagnosis, discharge, plan, conditions affecting activities of daily living)*

Education, Occupation

School ___________ **Grade** _____

i.e. special education, truancy/attendance problems, academic pressure, discipline, social challenges, recent school changes, bullying

Worksite ___________

i.e. discipline, conflicts with peers, supervisors, public, performance pressures

Support Systems and Other Involvement

Suspected Child Abuse ☐Yes ☐No

Family or Loved Ones, and other Significant Relationships

Protective *i.e. supportive, engaged, involved, new romantic partner, positive change of residence*	**Risk** *i.e. conflicts, parental separation/divorce, change in placement/address, grief/loss, illness*

Peers

Protective *i.e. group membership, sports involvement*	**Risk** *i.e. problems with friends, bullying, friendship/significant other break up*

Faith-Based/Spirituality

Protective *i.e. acceptance, non-judgmental, belief in a higher power*	**Risk** *i.e. intolerant messages, estrangement, condemnation, judgmental*

Identity Issues *i.e. gender, acculturation, other cultural challenges*

Social Networks *(Request email passwords to computer, Facebook page, text messages etc.)* *i.e. actual social relationships or online social networking activity*

Additional comments/thoughts/opinions

Recommendations made by ICAN based on the 2016 report.

School suicide prevention resources should be available to students throughout the year including non-school days and during summer and holiday breaks.

Mental health services should be available and delivered to all students regardless of income and Medi-Cal eligibility. If this is not feasible, assistance should be provided to help them locate appropriate mental health resources

School districts are encouraged to develop policies and procedures that utilize Employee Assistance Program resources to support school employees after the death of a student.

Q&A

Qualitative Data

What is the role of stakeholders in describing the problem of suicide and its context?

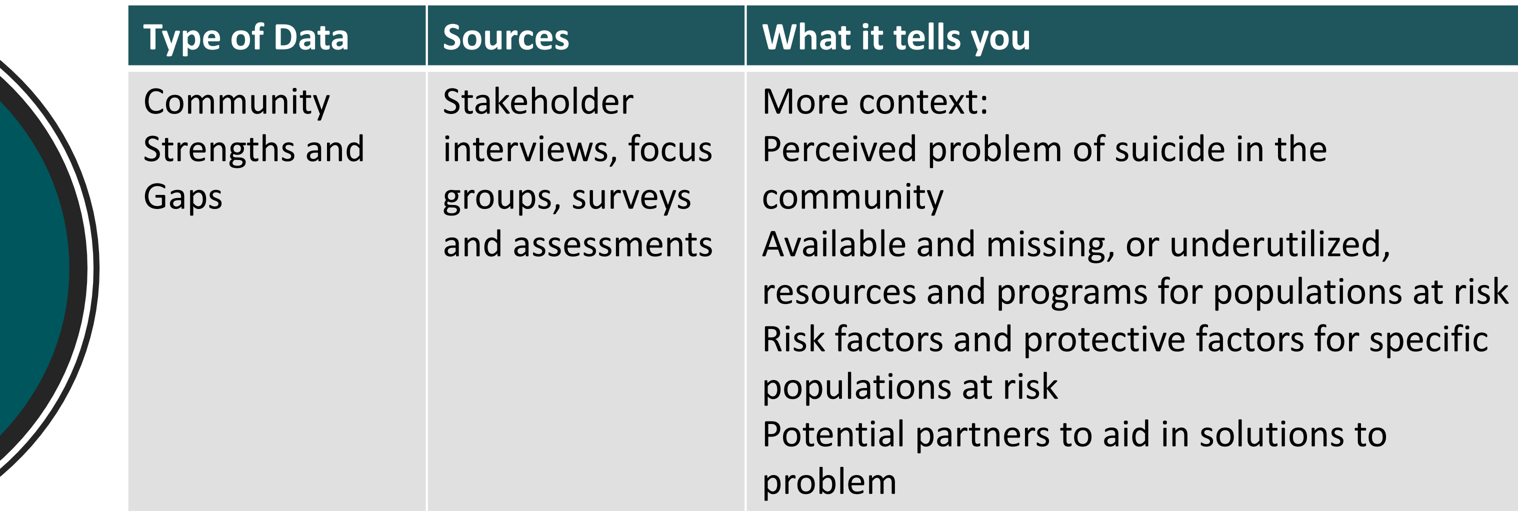
Help learn about risk and protective factors populations at risk

Help understand community perception of the problem

Secure buy-in and engagement

Identify cultural perceptions, needs, and cultural “fit”

Qualitative Data



Type of Data	Sources	What it tells you
Community Strengths and Gaps	Stakeholder interviews, focus groups, surveys and assessments	More context: Perceived problem of suicide in the community Available and missing, or underutilized, resources and programs for populations at risk Risk factors and protective factors for specific populations at risk Potential partners to aid in solutions to problem

Learning Collaborative
Nestor Veloz-Passalacqua
San Luis Obispo County

PREVENTION AND EARLY INTERVENTION

www.slocounty.ca.gov

SLO - Prevention and Early Intervention

Student Assistance Program

Original MHSA Work Plan to build wellness and resiliency, reduce risk factors and increase protective factors for middle schoolers.

- Some middle school needed continued support and assistance.
- Designed to have an wrap-around model: PEI Student Counselor, Family Advocate, and Friday Night Live Coordinator.

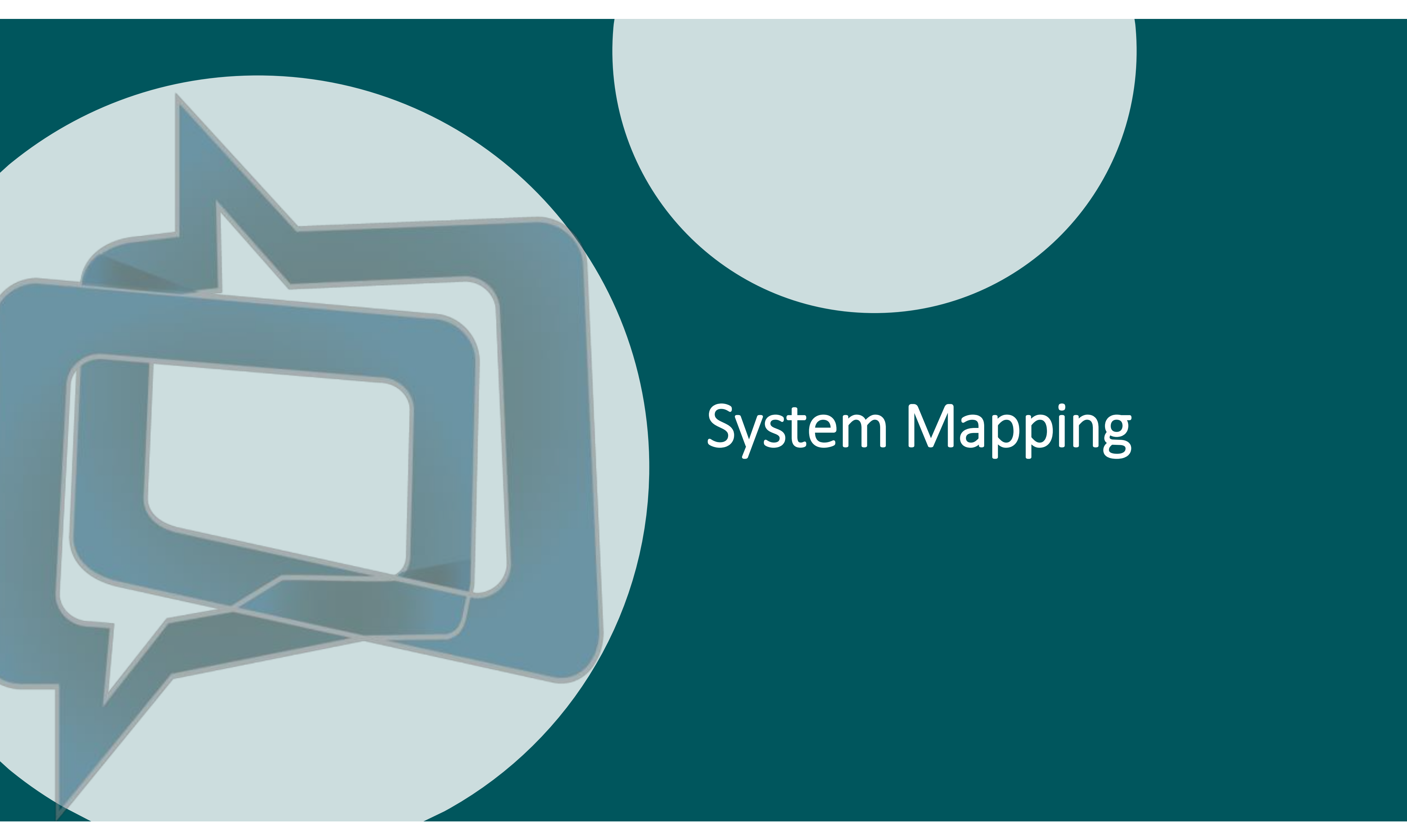
Conduct pre/post surveys on a quarterly basis:

- 229 unique total contacts
- 46% engaged in intensive case management services
- 86% managed cases showed progress in attendance and behavior.

LGBTQ Needs Assessment (NA)

- County had not current data on the needs/concerns of the community
- County received MHSA Stakeholder approval for a one-time expense on the NA
- County partnered with Cal Poly to complete the one-year long NA
- NA is conducted county-wide to get a larger sample size and employs two phases:
  - Online English/Spanish survey: Over 450 community members completed the online survey
  - Focus groups have been scheduled for the next few months
  - Findings to be available in June.

Q&A


System Mapping

- Identify resources and processes that are currently in place to identify and support those at risk of suicide.

- The **goal** of system mapping to provide a clearer picture of all supports in the process, the roles that other entities play, and the gaps that need to be addressed.

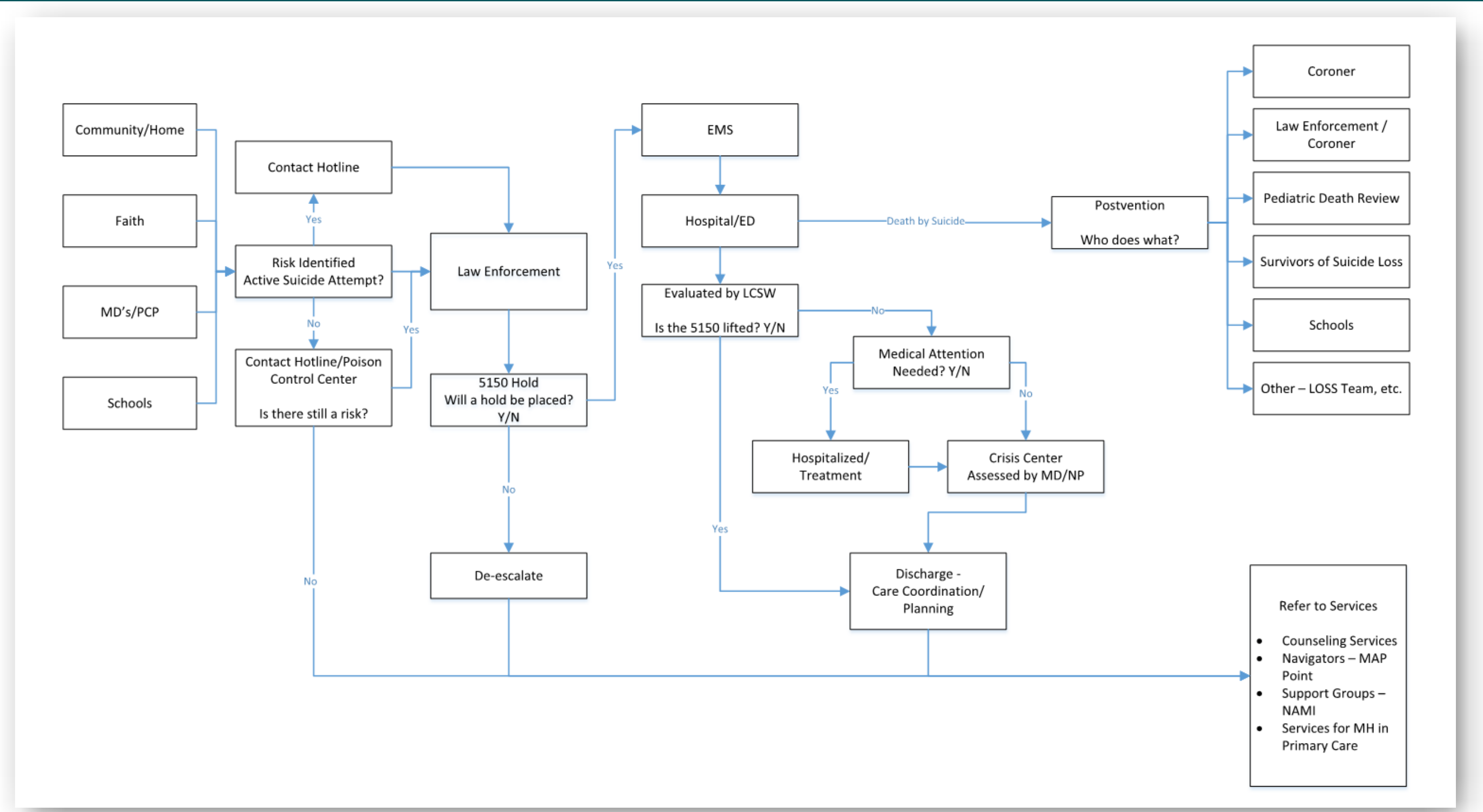
Levels of System Mapping

- In addition to creation of an overview document connecting various systems, for system mapping to be most effective, it should also occur at the individual organization level.

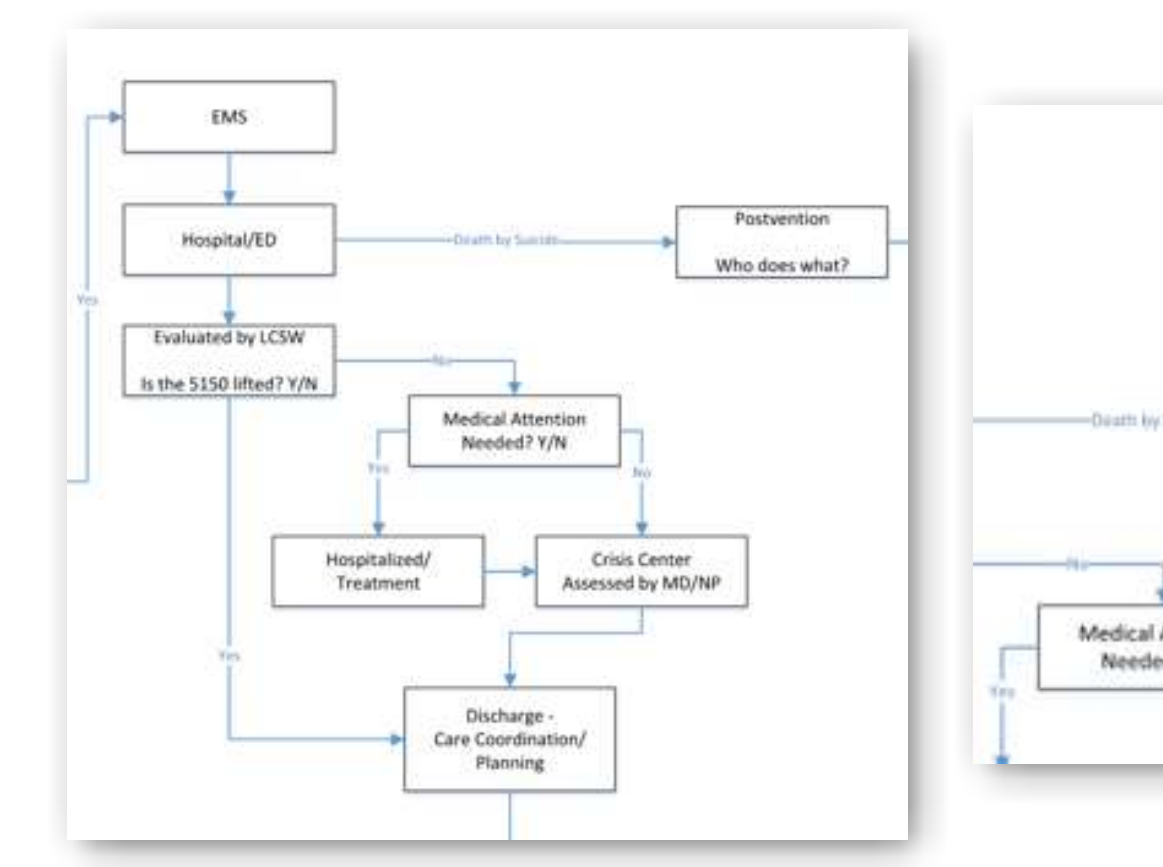
- For example, a school will want to map out the school specific process for identifying and responding to youth at risk.

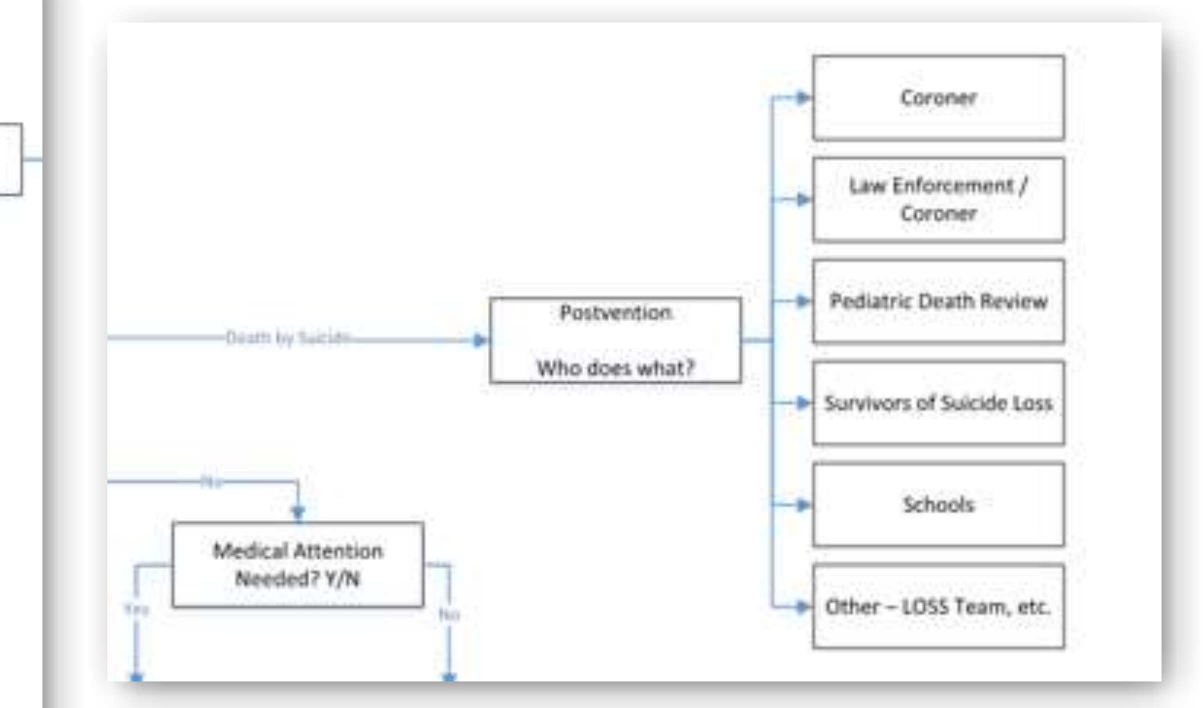
- Ideally your system map will demonstrate all of the points from early identification to crisis response, intervention, and postvention.

Mapping out your crisis response system

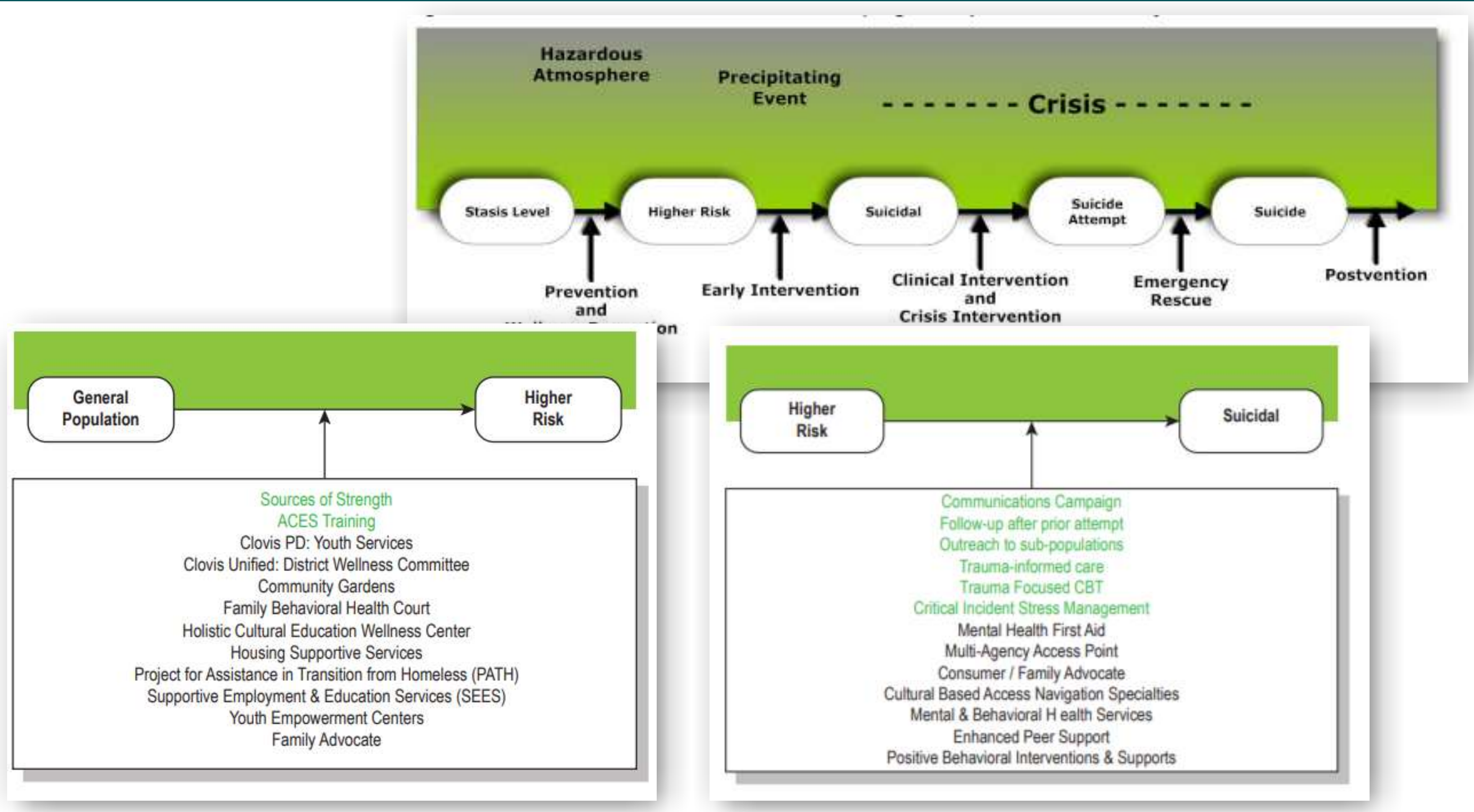


Mapping out your crisis response system





Mapping



Q&A

Status of Suicide & Suicide Prevention in San Diego County: 2018 Report Card

What do the data reveal about suicide? What is being done about it?

This Report Card brings together the most recent data available from multiple sources (for the years 2013 through 2017) to present a profile of suicides for all ages in San Diego County. Information from the County Medical Examiner, the Access & Crisis Line, hospital emergency departments, student self-reports, suicide prevention awareness campaigns and suicide prevention training programs are presented to provide a more complete understanding of the status of suicide and efforts to prevent them in San Diego County.

Indicator	2013	2014	2015	2016	2017
1. **Total Suicide Deaths (ALL AGES)**					
a. **Number**	441	420	427	431	458
b. **Rate per 100,000 population**	13.8	13.0	13.1	13.1	13.8
2. **Emergency Department Discharges:**					
Self-Inflicted Injury/Poisoning					
a. **Number**	2,870	3,263	3,248	3,098	-
b. **Rate per 100,000 population**	91.1	102.2	99.5	94.2	-
3. **Access & Crisis Line:**					
Percent of All Calls that are Crisis Calls	19.7	22.4	25.8	25.7	31.4
4. ***It's Up to Us* Media Campaign**					
a. **Annual Website Visits**	98,960	134,574	210,663	246,273	265,771
b. **Total Facebook Fans**	10,186	13,211	14,239	16,074	21,602
5. **Student Self-Report:**					
Percent of Students who Seriously Considered Suicide	-	17.5%	-	14.5%	-
6. **Suicide Prevention Gatekeeper Trainings**					
a. **Presentations**	90	116	101	100	157
b. **Participants**	5,112	6,390	2,747	1,937	3,627

SAN DIEGO COUNTY SUICIDE PREVENTION COUNCIL
ANNUAL REPORT TO THE COMMUNITY 2018

San Diego County Suicide Prevention Council Annual Report to the Community 2018

https://www.sdchip.org/initiatives/suicide-prevention-council/reports-resources/

SUICIDE IN SAN DIEGO COUNTY, 2016

JUNE 27, 2017
SPC ANNUAL STAKEHOLDERS MEETING

Joshua Smith, Ph.D., MPH
Epidemiologist
County of San Diego, Health and Human Services Agency
Public Health Services
Emergency Medical Services

LIVE WELL SAN DIEGO

HANDOUT

Funded by counties through the voter-approved Mental Health Services Act (Prop. 63).